NOVEMBER 1952

Mental Hospitals

Volume 3 Number 9

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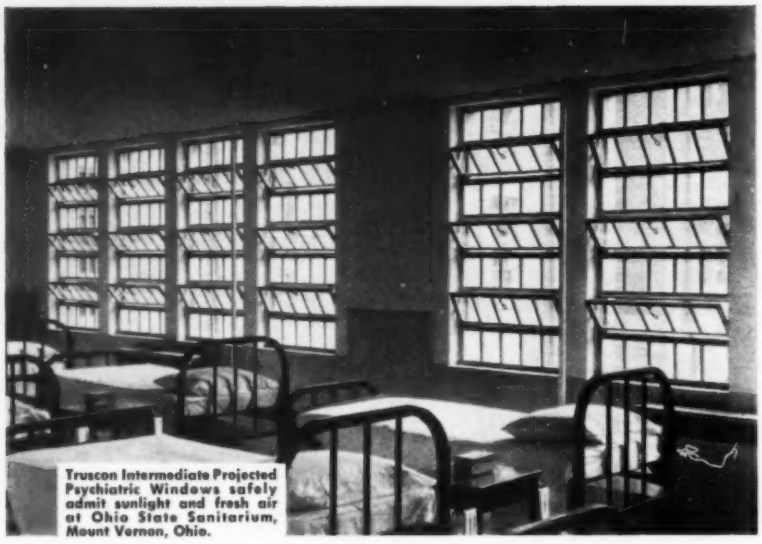
Dr. S. O. Johnson, Superintendent, Lakin State Hospital, West Virginia, receives First Achievement Award from Dr. Daniel Blain, Director Mental Hospital Service. L. to R.: J. Ernest Martin, Head of Oral Surgery, Hon. Joe Burdett, President State Board of Control, Dr. Johnson, Dr. Blain, Dr. Mildred Bateman, Clinical Director & Rev. William C. Bowie, Chaplain.



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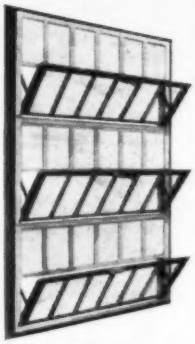

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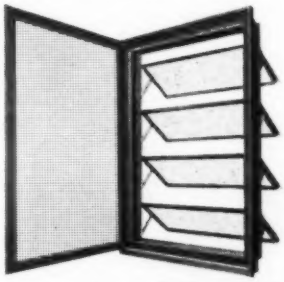

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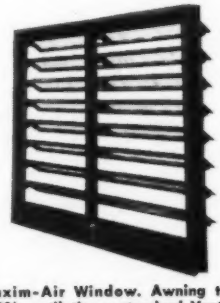

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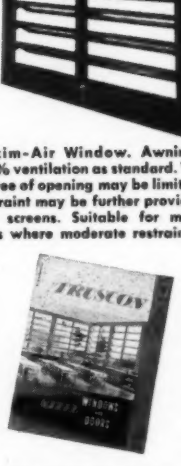

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EDITORIAL

Study of Research and Training in Mental Health

A STUDY OF STATE programs of research and training in the field of mental health has been undertaken by the Council of State Governments at the request of the Governors' Conference. The survey and resulting report will deal primarily with the status and nature of current research in psychiatry, psychology and related fields, with present training of mental health personnel, and with the much discussed topic of "preventive" mental hygiene. Major objectives are to provide factual data for governors and legislators, as the authorities responsible for mental health programs within their states, and to make such recommendations as may seem warranted for future planning of research and training activities by state mental health institutions and agencies. Careful consideration is being given to means of bringing the state hospitals into closer liaison with the teaching and research activities of medical schools, universities and similar centers.

Data on more than five hundred research projects conducted in state institutions throughout the country already have been collected. In addition principal researchers on these projects have been invited to indicate their views on a variety of subjects, such as topics on which research is most needed, major problems involved in their research efforts and the adequacy of public relations procedures connected with their activities.

The report will discuss examples of outstanding training programs for psychiatrists, clinical psychologists, nurses, psychiatric social workers, special therapists, psychiatric aides and other personnel.

Of special interest to the Governors' Conference is the possibility of greater interstate cooperation for research and training in mental health fields, in order that unnecessary duplication of facilities and effort may be avoided among the states and their agencies. Evidence of the potential success of such cooperative programs is already appearing from such projects as those provided under the Southern and Western Regional Education Compacts and the associated psychiatric training faculties in several cities.

The Council of State Governments (1313 East Sixtieth Street, Chicago 37, Illinois) would welcome the views and opinions of hospital administrators, and teaching and research personnel on these topics so that it may be guided by the experience of those most closely involved with progress in mental health.

Frank Bane, Executive Director
The Council of State Governments.

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Hospital Atmosphere Improved and Patient Recoveries Increased by Group Psychotherapy

By D. WILFRED ABSE, M.D. &
MARION ESTES, M.D.,
State Hospital at Raleigh, N. C.

THE APPLICATION of psychoanalytic principles to the treatment of in-patients in a mental hospital meets with considerable practical difficulties, especially with a grave shortage of trained personnel. This year we have used group work to bring a measure of psychotherapy to a large number of patients. At present four groups of patients with mental disorder and two large groups of alcoholics are involved in this project.

Two groups are composed of patients from open wards who were showing signs of remission of schizophrenia following a full course of insulin therapy. Another group is composed of patients who are approximately midway in their course of insulin therapy and yet another consists of patients selected simply on the grounds that they were considered suitable for group work with the hospital chaplain. All these groups are open, so that as a member leaves on discharge or probation from the hospital, his place is taken by another on the waiting list. Each group is composed of eight members besides the conductor and one other person, a medical student, a psychologist or a post-graduate nursing student.

The effects of this group work after eight months of operation must be considered in at least two categories: the general effect upon the total hospital atmosphere, and the effects upon the actual patient participants.

One important aspect of the first category will be mentioned here. The general social process outside the hospital, which has tended to exclude these patients—or from the patient's own point of view, reject him—often continues within the hospital, consciously or unconsciously. Under unfavorable conditions, such as inadequate medical direction and proper education in nursing attitudes, this rejection continues, in varying degrees, from admission ward to back wards.

Efforts are made, of course, to reverse this process and to ensure that the patients receive sufficient attention, respect as individuals and attempts at understanding. It has been definitely found that group work with patients, pushed to the limits of its practicability has a very powerful effect in reversing this unfavorable process. Channels of communication are opened up with ramifications far beyond the group participants, effecting nurses, attendants and other patients. The example set by the doctors in conducting the groups is not the least important item in favoring this reversal of the ignoring and rejecting attitudes which are otherwise often masked by mechanical treatment procedures.

The patient participants have been found to respond favorably in so far as the more limited aims of the group work is concerned. Ventilation of important problems which would otherwise go unnoticed, or at any rate, without sufficient discussion, often takes place. To quote a common example, a young married woman in commencing remission from a schizophrenic break with reality finds the courage to discuss her wishes and fears concerning her possible return to her husband and her wishes and fears concerning her possible return to her mother. A plan is evolved within the group that she should return to her husband, but only so far distant from her mother that she can visit or be visited at monthly intervals, yet not so near her mother that she does not have the opportunity of growing up. Such an example could of course be multiplied and expanded, but this serves to show that common "schizophrenic" problems are taken up, with benefit, in the setting of group support and interest which even extends towards some degree of insight as well as offering release and reality-testing. It is true that group work with schizophrenics requires much effort and stamina on the part of the leader, especially because hostilities of a group-disruptive type, which require vigilance and redirection often arise which make demands on the energy of the therapist. However, this is not the place to enter into these problems, except to mention that even if the group work is conducted on a predominantly support level, the patients benefit from their enhanced potential of communication and reality-testing. The overall impression is that remission is accelerated and the chances of relapse reduced. On the basis of the group experience, an occasional patient is selected for more intensive individual therapy.

Other advantages worth brief mention here are that the teaching of psychotherapy is improved by actual participation in the immediate process. The research value of group work is shown in disclosing common problems as felt by the schizoid personality.

In group "therapy" with the institutionalized male alcoholic, there is practically no "resistance" to participation. Although attendance is compulsory the group meets cheerfully, I believe in order to maintain the good will of the group leader, who, significantly, makes the decisions of administratively granting or curtailing certain privileges. As a group, the men verbalize fluently. It seems that long periods of silence create an anxiety which is unendurable to the more psychopathic members. Rather than remain discreetly silent, one member will always offer some subject for discussion.

There is a marked tendency for the group to discuss hospital policy, ward administration or other more objective topics rather than relate their own feelings. One gets the feeling that each member of the group wishes to conform to the mores of the group by presenting conventional excuses, platitudes, etc. rather than relating more fundamental material. Occasionally one person will seem to act as the group spokesman, always in a sycophantic and convincing manner. The predominant trend in the group is for each to rationalize his individual problem while quite openly admitting that there is a possibility that other people's drinking results from poorly adapted personality functioning, on the basis that "every alcoholic is a different case."

Although no claim is made that this program is curative, the benefits thought to derive from it are as follows:

1. The creation of a feeling of unity as a patient group rather than as a group of men who happen to be here as committed patients.
2. A general attitude of less suppressed hostility towards hospital committing authorities and families is engendered.
3. The group feeling that the ward physician is interested in their problem of alcoholism.

The aims of the group therapy are:

a) To resolve rationalizations, and thus let each alcoholic fully accept the emotional responsibility for his conduct, behavior and commitment to the hospital.

b) To implant the attitude that, in the light of our present knowledge, alcoholism is a type of adjustment necessitated by poorly adapted personality adjustment.

c) To encourage the alcoholic to seek further aid in defining, recognizing and treating his personality maladaptation by attending Mental Hygiene Clinics or to sublimate his problems in Alcoholics Anonymous or religious groups.

ADMINISTRATIVE INNOVATIONS DESCRIBED IN PRIVATE HOSPITAL REPORT

The 1951 Annual Report of one of our member hospitals, the Norton Memorial Infirmary in Louisville, Ky., contains much information which should be of especial interest to other non-public hospitals. (The Infirmary is a private, non-profit general hospital with a 43-bed psychiatric unit.) The following excerpts are reprinted from the Report as it was published in the Infirmary's employee publication, "The Capsule":

"An executive housekeeper with a national

(Continued on page 12)

INSTITUTE SHOWS MAIN HOSPITAL NEEDS

DESIGNS FOR HEALTH

(Our own abstract of President D. Ewen Cameron's speech at the Annual Banquet on October 20, 1952 at the Fourth Mental Hospital Institute, Columbus, Ohio.)

During this summer, a part of which I spent in Europe, I was deeply impressed by the leadership offered by North American psychiatry and what it means there. Dr. Blain's own reputation has spread to the extent that both the World Health Organization and the World Federation for Mental Health have requested his help in solving their problems. These problems are the same ones which confront us all—how best to establish designs for health in mental hospitals.

During the quarter of a century that I have been in practice in hospitals, I have seen some of the most exciting new ideas develop. These have been in terms of defining and attacking mental diseases of all kinds. The malarial treatment for syphilis came out of a mental hospital, and I remember so well how in the early days we kept netting around the patients' beds to keep in the infected mosquitoes.

In the early days of convulsive shock, treatment was given by intramuscular injection of camphor, and the biggest problem was the prevention of fractures. I have watched a patient, after such an injection, walking along on a good soft lawn, followed by an attendant to catch him as the convulsion came on!

But we are today on the verge of a new and even more exciting adventure in the treatment of mental illness. We are discovering how to loosen and manipulate the powers of the group. This power has been known for years in terms of morale, but it is only now that the structured group is being brought into play to help the patient in the mental hospital. It will take bold planning and brave hearts to develop this field.

We know the extent to which disturbed patients, for instance, can contaminate the rest of the ward, bringing on episodes which we have to consider as emergencies. Again, we know that the spread of disagreements among staff members can affect patients, and actually impair their progress. I have heard a yet bolder and very valuable concept—that a demoralized mental hospital staff can affect not only community attitudes but even the legislature itself. At the thought of fifty or sixty patients strapped to chairs in a hospital, the medical staff becomes demoralized and so does the legislature. You will hear them say that patients are not like other people—they do not feel like human beings.

Then we see the spread of excessive anxiety from staff member to staff member. This is particularly noticeable when there is a long line of authority between staff member and patient. Each one tightens up to avoid personal criticisms and the end result is overprotection of the patient. The patient will not try to assume responsibility for his own life if he lives in an over-secure mental hospital.

After all, the theory of therapeusis is to restore the maximum possible degree of freedom to the patient. When I was in Brandon, Manitoba, as long ago as 1929 we opened the wards. There are today no locked doors in the Allan Memorial Institute in Montreal, and in eight or nine years we have only lost two or three patients by suicide.

We have gone far in accepting the group as a factor in treatment. Not a group of a hundred—but of fifteen, twenty or twenty-five. This acceptance is being expressed in function; it is also being expressed in structure. We are building today not great massive blocks, but small ones.

Public attention is increasingly directed toward group formations. Some of the earlier ideas came from industry—the realization for instance, to what extent an informal organization exists beside the formal one. Thus, if one group produces say 60 units and another 25, the general informal group expectation that 40 will be produced overall brings the one group's production up to this figure and the other's down.

Similarly, patients whom the group expects will not be violent do feel a controlling influence. Group decisions, too, we have learned, are more likely to be followed than directions. Something intangible is transmitted when staff and patients work together as a group. We know that schizophrenics can be ambulatory for long periods with the help of contacts with staff members—and not necessarily trained ones.

We have a very considerable obligation to undertake social engineering. The movement in this direction exists everywhere. Business is increasingly being judged on its social adjustments as well as upon other factors. Economic man was always a figment of the imagination—today he is giving way to human man. Business now seeks to know what motivates human behavior—why people wish, for instance, to buy and to sell.

We have before us an exciting chapter indeed—a new attack upon individual diseases by the release and direction of the forces of the group. In mental hospitals opportunities are unparalleled for progress in this field.

FOURTH MENTAL HOSPITAL INSTITUTE OPENS

The Fourth Mental Hospital Institute opened at the Deshler-Wallick Hotel, Columbus, Ohio, on October 20, 1952, with a registration of 249, including more than 160 superintendents and medical staff, 30 business managers and lay administrators, 14 public officials including members of State Boards, 23 nurses, several chaplains, trustees and other staff members. The diverse program was centered upon the one person in the mental hospital who had sent no delegate—the patient.

Chairman of the local Arrangements Committee was Dr. George T. Harding, Medical Director of the Harding Sanitarium, Worthington, Ohio, who welcomed the delegates to the first session on Monday morning. Other members were Dr. Lowell O. Dillon, Commissioner of the Ohio Division of Mental Hygiene, Dr. Marlin R. Wedemeyer, Superintendent of Columbus State Hospital, and Dr. Ralph M. Patterson, Professor of Psychiatry at the Ohio State University Medical Center.

Immediately after the opening of the first session on Monday morning, Dr. Winfred Overholser, Chief Consultant of Mental Hospital Service, called for one minute of silence in memory of the late Dr. J. Fremont Bateman, former superintendent of the Columbus State Hospital, who died last March. It was through Dr. Bateman's arrangements, as a member of the M.H.S. Board of Consultants, that the Fourth Mental Hospital Institute was held in Columbus this year.

PRESENTATIONS AT ANNUAL BANQUET

TOASTMASTERS at the Annual Banquet of the Fourth Mental Hospital Institute were Dr. Lowell O. Dillon, Commissioner of Mental Health for Ohio, and Dr. Maurice Levine, Professor of Psychiatry for the University of Cincinnati School of Medicine.

Dr. Dillon introduced a special group of mental hospital superintendents, who had each completed more than 25 years of service in Ohio institutions. They were Dr. Arthur G. Hyde, Massillon State Hospital, Dr. E. A. Baber, Longview State Hospital, Dr. C. C. Kirk, Orient State Institute for the Feebleminded, Dr. C. H. Creed, Athens State Hospital, Dr. R. E. Bushong, Lima State Hospital and Dr. Guy H. Williams, Hawthornden State Hospital, Macedonia.

Dr. S. T. Ginsberg, Chief Professional Services at the Veterans Administration Hospital, Marion, Ind., was then introduced, and presented an inlaid wooden gavel of walnut and maple to Dr. Winfred Overholser, Chief Consultant to the A.P.A. Mental Hospital Service. This gavel was specially made for M.H.S. by the patients in the occupational therapy department of the hospital.

Dr. Maurice Levine, in a brief talk, pleaded for closer relationships between medical schools and universities and all State Hospitals.

Dr. Daniel Blain, Medical Director of the A.P.A. and Director of the Mental Hospital Service, presented the 3 Achievement Awards for the current year. They went to Dr. S. O. Johnson, of Lakin State Hospital, West Virginia; Dr. R. C. Rowell, of Austin State Hospital, Texas; Dr. J. T. Naramore, Larned State Hospital, Kansas. Honorable Mention Certificates went to Dr. H. B. Knowles, Peoria State Hospital, Ill.; Dr. Harry J. Worthing, Pilgrim State Hospital, West Brentwood, N. Y., and Dr. Jess V. Cohn, Embreeville State Hospital, Pa.

The Responsibility of Public Mental Hospitals in Psychiatric Research

By JACQUES S. GOTTLIEB, M.D.
Asst. Dir. Psychopathic Hospital, State University of Iowa
(Abstracted with the author's permission by the editorial staff of MENTAL HOSPITALS)

I AM CONVINCED that the only way we can solve our basic problems in psychiatry is through the application of the scientific method, and there is great need for the acceleration of research.

The most pertinent question is whether the complex subject matter of psychiatry is sufficiently formulated to lend itself to exploration and development by scientific methods. I firmly believe that it is.

The methods of science, cumbersome as they are, are the most potent devices yet developed to advance knowledge. They have consistently transcended the most brilliant of man's philosophical efforts.

Psychiatry, because of the breadth of its scope, has followed in part the development of the biological sciences. But it has depended equally upon the development of its own discipline and that of the social sciences. Various sciences have their own tempo of development, and based upon David Shakow's concept of this variation of tempo we might say that physics, chemistry and the biological sciences have reached adulthood, while psychiatry is still adolescent. Social sciences could be considered still in their infancy.

Nevertheless, it seems probable that present day psychiatry is able to advance rapidly as a science through collaboration with other disciplines. It is poised to enter the second or experimental phase of development. To do this, it must move from the clinic to the laboratory.

Despite the readiness of psychiatry for such an advance, two other things must happen: one is the recognition by psychiatrists in general of the need for research, the other is the readiness of public psychiatric hospitals to assume responsibility for the support of research.

Dr. Kubie, in a recent paper entitled "Research in Psychiatry is Starving to Death" emphasizes that financial support for psychiatric research is inadequate and hard to obtain. This is undoubtedly true, but I believe it is due to negligence on our part in informing the public of our lack of knowledge and of our need for such funds. One of the objectives of the Regional Research Conferences being sponsored by the American Psychiatric Association is to impress the attending psychiatrists with the need for research. Until psychiatrists as a group express these needs aggressively among themselves and to the public, progress will remain slow.

It seems to me too that the public psychiatric hospitals must be willing to assume the responsibility for research because of the nature of the research which is now needed. The public mental hospital is an ideal place to carry on these investigations. The basic plant is constructed and maintained and the patients are in residence. All that is needed are investigators, their assistants and their equipment.

The public mental hospitals cannot depend on the clinician and the private practitioner to solve their problems. The hospitals themselves must assume the responsibility for the study of all forms of therapy, including psychotherapy. If they will assume this responsibility they cannot help but become progressive institutions, since the successful functioning of our hospitals is dependent on the skill and capacity of their personnel. The addition to a hospital of a research group, if well integrated, will go far to improve the caliber of the entire staff.

This is not because investigators themselves are superior individuals. But the trained investigator is guided primarily by a spirit of enquiry. He applies his techniques to the how, why and what. His imagination, an important aspect of his functioning, is not free-floating phantasy, but controlled and trained by his discipline. He remains relatively objective and continues his tasks irrespective of whether he confirms or refutes the hypotheses he is testing. If these characteristics are permitted to permeate the institution, an attitude of healthy scepticism will be maintained, a more tolerant attitude developed and a more scholarly approach to the problems of psychiatry will be voiced. Dogma, empiricism, and the authoritarian attitude will be challenged. The functioning of the hospital staff may become more democratic, enthusiastic and active. This functioning will have appeal to students, to scholars, to those who wish to be associated with a progressive institution. The institution will become dynamic rather than static. Thus the caliber of the professional staff will be improved from the staff physician, the nurse and the social worker to all the ancillary personnel.

It is no easy task for the administrator to integrate a research program within the functioning of his institution. An isolated research unit, peripheral to the total functioning of the hospital, will carry little of the desired influence or impact.

Unless the administrator is convinced of both the romance and the need for research, he will be unable to accept either his responsibilities for the development and maintenance of the unit, or the innumerable irritations which such a unit will bring. It is in part his responsibility to obtain and budget funds as well as to arrange for space and equipment. He must remain aware that research moves slowly and that his investigators need plenty of time whether they have other duties or not. He should insist that the aims of the research are clearly stated and adhered to. And lastly he must protect his research personnel from the vicious encroachment of their time by the red tape of questionnaires and reports.

Research is extremely expensive and cannot be conducted on a shoe string. In the past funds for psychiatric research have been negligible, many states having no allocation of funds for this purpose at all. The total spent by the nation, from all sources, governmental and private, for research was $4.15 per mental patient under treatment, in contrast with $28.20, $27.70 and $26.80 per patient for infantile paralysis, cancer and tuberculosis respectively. This is in considerable contrast to many industries which spend between 3 and 4 per cent of their gross income on research.

However, the Council of State Governments has as one of its primary projects the study of mental health research resources and needs of the 48 states. Included in this study is the amount of support for research and the results being obtained to date. It is probable that as a result of these studies, there will be recommendations for increased funds for psychiatric research.

One sometimes hears that additional funds are not needed, because funds now available are being wasted by investigation of "poor" ideas. This statement I challenge. It is difficult to evaluate an idea particularly if it is contrary to tradition. It would be more legitimate to criticize the experimental methods being used, which are too often inadequate and amateurish. The Regional Research Conferences will have succeeded if they do nothing more than lead to improvement in the caliber of methods being used.

There is of course an extreme shortage of trained personnel. Psychiatrists cannot delegate more than collaborative responsibility to investigators from other disciplines. We as psychiatrists must assume the responsibility for psychiatric research. We are in need of a program for the training of psychiatrists in the principles and methods of investigation. A step in the right direction is being taken by the A.P.A.'s Committee on Research which hopes to stimulate this training for more psychiatrists during their residency period.

However, investigators will remain all too few unless at least two changes occur in our present functioning: One is an elevation of the cultural status of the investigator to approximate equality with the successful clinician. This may occur when we as a group are willing to express both our limitations in knowledge and our need for an increase in knowledge; when administrators actively and enthusiastically support research in their institutions; and when investigators are no longer isolated, but integrated into the total functioning of the hospital. Secondly, the financial remuneration of psychiatric investigators must become commensurate with clinical practice.

One often hears the statement that the major research productivity of an individual occurs during the early part of his career. As he grows older the investigator's family enlarges and his financial responsibilities increase. All too often he must seek increased financial remuneration to meet these responsibilities, and this is often most easily obtained by turning to administration or clinical practice with consequent sacrifice of research interests and activities. Thus he reduces the total available of such experience and skill. The numbers are too few for psychiatry to allow this to continue.

In the discussion which followed this paper, Dr. Blain pointed out that other types of research are going on in mental hospitals besides clinical psychiatric research. He mentioned specifically the ward observation studies sponsored by the Russell Sage Foundation, and the evaluation of plastic dishes which was reported on at the first Institute session. He also said that the Conference on Psychiatry and Medical Education had brought out that teaching itself could be conducive to research, that the instructor can point out areas of psychiatry where knowledge is lacking. Dr. Gottlieb said that more collaboration is needed between basic scientific researchers and psychiatrists. Without this direction, he said, there can be no mutual satisfaction with what basic science research can offer to psychiatry. Dr. Gottlieb also offered the resources of his A.P.A. Committee on Research to look over and make suggestions for improvement on any research protocol. He further suggested that the laboratory facilities of commercial concerns, such as pharmaceutical companies, can be used for collaborative studies that will be of eventual benefit to the concern.

ARCHITECTURE BASIC PROBLEM

It was evident from the large attendance at the opening session of the Institute that all delegates were vitally interested in the problems of Mental Hospital Design, Construction and Furnishings. Dr. Overholser described briefly the conference between psychiatrists and architects held last spring in Washington, and despite the chairman's efforts to direct the discussion towards functional ward and other furnishings, questions from the floor again raised the fundamental issues about size of hospitals, size of nursing units, how the hospital itself could best be designed for intensive treatment programs and where such basic information could be obtained.

It was proposed by one delegate that the Mental Hospital Service should make as many studies as possible upon the use of various types of materials, furnishings and equipment used in mental hospitals, and send out to members, if not recommendations, at least information regarding the durability, appearance, cost and efficacy of various new materials, particularly plastics and related materials. Perhaps the Bureau of Standards in Washington, D. C., might be able to supply some interim information which would help superintendents and business managers decide between various alternatives on the basis of informed rather than uninformed opinion.

This suggestion arose out of a discussion upon the use of plastic dishes versus china. A show of hands indicated that at least half the hospital superintendents had been using plastic for some time but some of them had had difficulties with cleansing, in discoloration and distortion of the material.

Regarding the ideal size for nursing units, most delegates apparently agreed with Dr. D. Ewen Cameron, President of the American Psychiatric Association, who said that the one- to four-bed unit could best supply the proper setting for treatment of the mental patient, who does not spend much more time in bed than do other people. It was pointed out however that the question of paying for and of getting personnel was often operative in forcing a superintendent to have larger nursing units than he would really prefer.

THE NEW NOMENCLATURE AND ITS STATISTICAL ASPECTS

Dr. George Raines, Chairman of the American Psychiatric Association Committee on Nomenclature and Statistics, introduced the session on hospital reporting by a brief explanation of the plan of the revised nomenclature.

It was inevitable from the nature of the nomenclature, said Dr. Raines, that there would be certain conflicts between its clinical and statistical aspects. A clinical nomenclature should be flexible, should have many categories, and should allow for overlapping. A statistical nomenclature, on the other hand, needs rigidity, few categories and those categories should be mutually exclusive. Conflicts therefore were inevitable and would have to be ironed out point by point. Nevertheless, once the nomenclature was thoroughly understood, it would allow the physician to make any diagnosis, however qualified, and the statisticians could still count it. Statistics could only be as good as the nomenclature used.

Dr. Morton Kramer, Chief, Biometrics Branch of the National Institute of Mental Health, presented comparison sheets showing changes between the old and the new nomenclatures. There were not, he said, many basic differences and he invited enquiries on any statistical problems which might arise.

Some delegates thought that the section on mental deficiency was insufficiently qualified but Dr. Kramer pointed out that many subdivisions were already too fine from the statistical point of view. While the Biometrics Branch does not use them all, it seemed easier to ask hospitals to send their data exactly as they had collected it for their own use than to have to do an extra analysis for the National Institute of Mental Health.

There was considerable discussion about "acute brain damage" and "chronic brain damage." Dr. Raines said that the terms "chronic" and "acute" were used in their pathological sense, not in their clinical sense and this had to be borne in mind in indicating the diagnosis. The basic difference between the revised nomenclature and the older one was to restrict the term "psychosis" to the three major categories of mental illness —schizophrenia, paranoia and manic-depressive syndromes.

Later in the session Dr. Kramer described the meanings and uses of certain statistical tables he had presented to the meeting. Statistics, he said, could be a valuable tool to the administrator, not only from a legislative point of view, but also to help him evaluate for his own uses the work going on in his hospital.

OVERCROWDING STIMULATES REHABILITATION PROGRAMS

If psychotherapy deals with the liabilities of the mental patient, rehabilitation deals with his remaining assets, said Dr. Benjamin Simon, Director of the Ring Sanatorium, Arlington, Massachusetts, Chairman of the discussion on Rehabilitation. The hospital, however, could only go so far, without the help of the outside community. The problem is in which way the community can be brought into the program so that the patient may make a successful community readjustment when the time comes. Dr. Lucy Ozarin of the Veterans Administration said that we need to speed up the community resources.

Dr. John M. Mackenzie, Boston State Hospital, Massachusetts, described an experiment in rehabilitation now going on, which was designed to find out whether in fact rehabilitation was really worth while, and if so, who could best operate such a program. Any patient who is discharged during the period of the study will be followed up in the community to determine how well his adjustment is maintained. Another question to be determined is whether a rehabilitation program will cut down on readmissions.

Dr. U. Schutzer, New York Department of Mental Hygiene, described a program in Binghamton whereby a large industry refers its employees on occasion to the state hospital and is prepared to receive them back when they are well enough. For those who can make a proper adjustment only imperfectly, there is a "sheltered workshop" which keeps them self-supporting.

Dr. Edgar C. Yerbury of Connecticut State Hospital, Middletown, described a program whereby a counsellor visited the hospital and finally became a full time worker. This, he said, had been a gratifying experiment. Funds were obtained for follow-up care, and vocational training in certain trades was set up in the hospital itself. Education was arranged in other fields at community trade schools.

Dr. Jordan, of the Provincial Mental Hospital, Edmonton, Alberta, said that in one small town most of the business men were known to the hospital, and they were called upon when the Superintendent had a patient who might fit into their organization.

Dr. E. A. Baber, Longview State Hospital, Cincinnati, Ohio, said that this was one area in which overcrowding offered stimulus for a good program. It was a practical way of saving the hospitals money.

Dr. Cleve Odom, Arkansas State Hospital, said that much indeed could be done by community activities, and that the lack of formal rehabilitation staff need not interfere, provided sufficient community interest could be aroused, so that volunteers too could enter into this program.

NURSING PROBLEMS IN MENTAL HOSPITALS

DR. HARVEY J. TOMPKINS, Chief of Psychiatry and Neurology for the Veterans Administration, led the discussion on "Nursing Services and Education in the Mental Hospital." He was aided by Miss Helen M. Edgar, Director of Nursing at the Philadelphia (Pa.) State Hospital, and Miss Lavonne M. Frey. Miss Edgar defined the functions of the several members of the nursing service, emphasizing that the Nursing Department should be headed by a Director of Nursing responsible directly to the Superintendent, and responsible for the nursing care of all patients. The organization of nursing service should be flexible in delegation of duties, but full collaboration among the various divisions is essential to ensure integrated nursing coverage. Continuous cooperation between the nursing instructors and the nursing staff is especially important, Miss Edgar said. She delineated the structure of the nursing team, defining the functions and requirements of each member.

Miss Frey, who is Chairman of the Department of Psychiatric Nursing at the University of Pittsburgh School of Medicine, elaborated on the practices and problems of nursing education. She cited the progress being made in this field despite the limited number of psychiatric nurses currently available. She stated that the core of the program is clinical instruction, and referred to the hospital ward as the "laboratory". Too often, however, there is a large gap between the ideals of classroom theory and the realistic situation.

Regarding in-service nursing education, Miss Frey said that such a program, if properly planned, "is not wasteful of hospital time nor essentially costly if one could measure the added value of the employee to the institution." This program should be in two parts, she added, one to meet immediate needs, and "the second, the continuing program which provides opportunity for the worker to progress with ever-increasing awareness of his function and responsibility."

The discussion from the floor brought a number of contrasting opinions on the reason for the current shortage of psychiatric nurses. Several nurses felt the shortage was self-perpetuating; that the examples of psychiatric nursing which students encounter in overcrowded, understaffed public mental hospitals are understandably discouraging. Also, the prospect of having to assume responsibility without adequate supervision is somewhat alarming to a nurse just out of training.

A number of doctors felt that re-opening the basic schools of nursing in psychiatric hospitals would help to keep more nurses in the psychiatric field. Dr. John Smalldon, Superintendent of the New Hampshire State Hospital, said that his hospital has kept its basic school, graduating twenty nurses a year. New York state also retained its basic schools in the state hospitals, and has 28% of all the registered nurses in the country working in its institutions. Dr. Walter Baer of Illinois said that in his state there has been a notable decrease in the number of psychiatric nurses since the basic schools in the state hospitals were closed down. They are trying to recoup their loss by intensifying the training given to aides, but so far they are still behind. Dr. George Jackson of Texas, where psychiatric aides can attend junior college for a two-year intensive course in technical nursing, said that aide training programs were encouraging more aides to go on to the nursing profession. He also felt that psychiatrists should be do more towards helping the nursing and aide groups to reach their goals. Another critical factor in the nurse shortage, Dr. Jackson pointed out, is the low salary scale. Mr. Robert Klein added that the turnover cost is tremendous and if more money were spent on salaries, less would have to be spent on training replacements.

PSYCHIATRIC AIDE TRAINING WORKSHOP REPORT

IN CONJUNCTION with the session on nursing services and education, Dr. Leo H. Bartemeier reported on the Third Psychiatric Aide Training Workshop held at the LaRue D. Carter Memorial Hospital in Indianapolis just prior to the Institute. Thirty-two persons attended this Workshop, which was the last in the first series of such discussion sessions. It was suggested by one delegate, Dr. H. B. Lang of New York, that the affiliate societies of the American Psychiatric Association foster regional meetings to discuss planning psychiatric aide programs.

Committee Reports Accepted

Dr. Bartemeier presented a brief report of each of the five committees into which the workshop group was divided. The Recruitment and Placement Committee recommended that complete job descriptions be formulated as well as minimum standards of education, experience and personal characteristics. An outline of areas which should be included in training courses was presented by the Committee on Training Content. It is the instructors' responsibility to make training meaningful, asserted the Committee on Training Methods, for aide training should be more than developing technical skills. The Committee on Utilization indicated areas of responsibility which each level of aide can assume.

Disagreement On Licensing

The reports of the fifth committee, on Practical Problems, was not accepted by the Workshop's plenary group. This committee raised the questions of whether there is a need for aides, whether the aide's job is nursing, and how it compares to practical nursing. It also examined the need for professional status and licensing of trained aides. There was much disagreement among the individual Workshop delegates as to how these questions could be answered, and particular dissension arose over the concept that the training of psychiatric aides is an expedient to provide care for the hospitalized mentally ill in view of the shortage of psychiatric nurses.

IMPORTANCE OF TRAINING MENTAL HOSPITAL HEADS

DR. C. N. BAGANZ, Manager of the Veterans Hospital, Lyons, New Jersey, was discussion leader on the session about the training of hospital administrators.

Dr. Baganz gave an outline of the results of a questionnaire recently sent out to American Psychiatric Association members by the Ad Hoc Committee on Qualifications and Training Standards for Mental Hospital Administrators, of which he is the Chairman.

The majority of those polled feel that a mental hospital administrator should be a psychiatrist, preferably certified by the American Board of Psychiatry. This administrator should have had from two to five years' experience, and should have received a course of formal education in administration ranging from three to twelve months.

This formal course should give chief emphasis to, but not be limited to community relations, personnel management, medical care and the legal aspects of psychiatry.

It was felt by most who answered the questionnaire that the A.P.A. and its Executive Committee should take definite action to form and operate an agency for the purpose of certifying and approving the qualifications of prospective mental hospital administrators.

It also appeared that all members polled felt that there was definite need for prompt and definitive action in this area in order to produce physicians properly trained to handle a superintendent's job.

During the discussion which followed Dr. Baganz' report, some of the group said that action should be taken somewhat conservatively, so that the entire program could be carefully and constructively built.

It was pointed out that schools and courses in hospital administration already existed, and that while these were in general geared to the needs of the general hospital, there was something of interest to the mental hospital administrator as well. On the other hand, Dr. Addison M. Duval pointed out, the mental hospital administrator had a contribution to make to these courses, though few of them took any part in this activity.

Dr. E. A. Baber of Ohio said that, on the contrary, he and several of his colleagues were members and had attended several of the meetings.

Dr. Mesrop A. Tarumianz said that he was in disagreement with the basic philosophy of these courses. He too had attended some of them and they subscribed to the belief that a hospital administrator need not be a physician—quite the opposite of the view held in psychiatric hospitals.

Dr. Duval suggested that a sort of workshop course be set up on a voluntary attendance basis, so that some experience could be obtained as a basis for further discussions.

Dr. Baganz asked for a motion that some positive action be taken as quickly as possible, but Dr. Duval objected that the Institute, with its shifting membership, was not structured to pass such a motion. Dr. Baganz agreed that this was a valid objection but a show of hands indicated that nearly all present were in favor of going ahead.

DIFFICULTIES OF EVALUATING PATIENTS' PROGRESS

Dr. Jess V. Cohn, Superintendent of the Embreeville (Pa.) State Hospital, conducted the second session of Monday morning's program, "Evaluating Patient Progress." He pointed out the difficulties, such as semantic differences and inadequate statistics, in even discussing the subject. Dr. Cohn said, however, that in addition to the several rating scales now in use, such as the Malamud-Sands, psychiatrists can utilize the observations and skills of psychology and social work.

Dr. George S. Stevenson, Medical Director of the National Association for Mental Health, mentioned the study being conducted at the University of Illinois to measure the mental health of a "normal" individual. Present day rating systems will probably be modified in accordance with their findings, he said.

Dr. Benjamin Simon said that overcrowding sometimes forces the premature rating of patients for discharge. He himself has found valuable the criteria for normalcy set up by a British psychoanalyst named Glover, first, that the patient must be free of mental symptoms and be assurably capable of adjusting outside of the institution and not merely display an abatement of delusions; second, that he must be unhampered by emotional conflict; third, that he must be able to do a satisfactory day's work, and fourth, that he must be able to relate to others. These criteria must of course be used on a sliding scale basis.

Dr. Simon added that the psychiatrist should beware of a seemingly good hospital adjustment, since it is sometimes just a surface adjustment assumed as a means of getting out of the hospital. A good rating scale is one which is objective and descriptive, avoiding any specialized terminology which can be variously interpreted.

One of the foremost studies of patient progress, the Stockton Pilot Study, was mentioned by Dr. Ewing H. Crawfis, Deputy Director of the California Department of Mental Hygiene. This was the 18-month experimental "total push" program conducted at the Stockton (Calif.) State Hospital to determine whether intensive care would enable regressed "back ward" patients to return to the community, and thus justify the expense of "total push" in the light of long-range economy. The results of the experiment were dramatic, but Dr. Crawfis said that the Department of Mental Hygiene was not yet ready to use it as an argument in favor of increased appropriations for the hospitals.

Dr. Addison M. Duval, Washington, D. C., voiced the opinion that the public mental hospitals were not yet ready to offer more discharges in exchange for more money; that it should be demonstrated to budget officers that raising the standards of care is justification enough for increased appropriations. Dr. Hayden H. Donahue of Texas, however, felt that you *must* be able to tell the legislature something about the results from the money you are asking for.

In discussing the adverse publicity that accompanies any mental hospital parolee or ex-patient who fails to make good in the community and must be readmitted, one administrator emphasized that chronic factors and "scarring" must be taken into account, that the psychiatrist should have no more cause for self-recrimination than the surgeon whose patient is readmitted for further surgery.

Concluding the program, Dr. Cohn said that the opinions and uncertainties voiced during the session would lend justification to the A.P.A.'s attempt to set up a Commission on the Evaluation of Therapies.

PATIENT FOLLOW-UP AND DAY CARE

The problems of several states and provinces in following the community adjustment of patients after discharge were discussed. Dr. Lowell O. Dillon, who was chairman of this session, mentioned that in Ohio all patients are put on a one-year trial visit before being discharged from the hospital's jurisdiction. During the year the patient's progress is checked and reported on by social workers. Dr. Allen E. Davidson of British Columbia cited the difficulties encountered in that province due to its unevenly distributed population. Since two-thirds of its one and a half million population is concentrated in the southwest corner of the province, and the remainder scattered throughout a vast expanse of territory, the mental hospital must rely on public health workers to keep track of a number of its discharged patients. The Provincial Mental Health Service has established two supervisory establishments in Vancouver, where patients can be transferred when preparing for discharge and job placement if they have no other resources.

In California, where the courts can commit patients to any of the state mental hospitals regardless of district, it was found that social workers from several different hospitals would be operating in the same community. The solution was to establish a centralized Bureau of Social Work, which now had 120 social workers, with one supervisor to each six caseworkers. To offset the impersonal nature of this system, particularly in "difficult" cases, the caseworkers attempt to visit as many as possible of the patients to whom they are assigned before the patients leave the hospital. Dr. Ewing Crawfis said that his state also hoped to make more use of the family doctor to keep the hospitals informed of discharged patients.

The developing trend for day care was also discussed. Dr. Ralph M. Patterson outlined the program at the new Columbus State Receiving Hospital. Each day's session lasts from 8:30 to 4:30 and consists of two group therapy periods, one of occupational therapy, one of recreational therapy, a rest period, and an hour of psychotherapy for those patients for whom it is indicated. The patients are assigned to this program a few days before leaving inpatient status in order to become acquainted with the program. Later they progress to outpatient clinic visits, and ultimately to complete discharge. Dr. Cecil Wittson of Nebraska added that this type of complete day care costs approximately forty per cent of usual inpatient care.

CARE AND TREATMENT OF THE PSYCHOPATH

In the session on care and treatment, the psychopath was described as a person who "knows the words but not the music." This reference was made by Dr. Benjamin Simon in telling of a study of a group of psychopathic girls, ranging in age from eighteen to twenty-one, who were inmates of a reform school. Two batteries of tests were given this group and to a control group of nurses of the same age. The test questions were of the "what would you do if . . .?" type, and concerned problems of ethical and moral principles. In the first test, which was sentence-completion, the results were about what could be expected. In the second test, however, where a "right" and "wrong" choice were offered, the psychopathic group outdid the nurses in selecting "right" answers. Thus it was illustrated that the psychopathic group were facile in selecting answers which would gain approval, although they didn't know the "music"—the feelings and conscience—which motivated the answers of the "normal" group, the nurses. Dr. Simon also referred to the psychopath as "an individual who bears all the trappings of a sane, normal individual . . . and knows how to play the game of sanity."

Sexual Psychopaths Treated

The problem of the sexual psychopath received much attention in this session. Dr. Robert E. Wyers, Superintendent of Norwalk State Hospital where the sexual psychopath unit for southern California is located, said that they have about three hundred sexual psychopaths under treatment there. Owing to their limited staff, space and knowledge, he said, they retain only the cases they judge as treatable. These patients are treated in small groups of seven or eight, and there are two psychiatrists and two psychologists attached to the unit to do therapy. The patients have formed a self-help group along Alcoholic Anonymous lines which they call the "DV-8's," and publish their own paper. The hospital encourages mixed recreation, such as dances, under supervision. At Norwalk State Hospital, which contains the sexual psychopath unit for northern California, they are using psychodrama as an attempt to treat these patients.

Dr. Ewing Crawfis of the California Department of Mental Hygiene mentioned the research projects being carried on at the University of California. There they are doing a study of the histories of sex offenders, as well as biochemical and physiological tests, and have completed a psychiatric evaluation of forty-six child victims. In the latter study it was found that the children's reactions to the incidents were patterned after their parents'.

Dr. Raymond Waggoner concluded with his own thought that treatment is primarily prevention. He feels strongly that more units for residential care of mentally disturbed children would enable a large percentage of incipient psychopaths to be treated before the condition becomes permanent.

SIMULTANEOUS SESSIONS ON VARIOUS TOPICS

SIX SIMULTANEOUS sessions were held for special interest groups on Tuesday morning, and designated reporters gave a brief account of each to the plenary session afterwards.

Dr. George S. Stevenson, speaking of the patterns of organization and administration of state hospital systems, said that the problem was complex, with many intangibles. Interdepartmental collaboration was essential, and so was collaboration with the Departments of Health and Education. In Canada most provinces were responsible for the care of their mentally ill, but it was not the case in all states. In Nova Scotia the responsibility was divided between the counties and the provincial government and a similar situation existed in some states here. A central structure would simplify such matters as joint purchasing, as well as enabling hospitals to have the benefit of specialists and experts at state level.

On the discussion of private hospitals and their administrative relationships with public authorities, Dr. Harrison Evans said that the group had come to no definite conclusions on this controversial problem. Components of the problem were the protection of the patient, the protection of the private institution in the matter of law suits, and the authority to lock doors. It was, however, decided that the final authority to lock doors rested with the State authority. Further study was needed to determine the optimum state authority and what procedures could and should be delegated.

Dr. Gale Walker of Pennsylvania reported upon the discussion on the care of the epileptic patient, assisted by Dr. William Fox of Illinois and Dr. R. B. McIntosh of Pennsylvania. Dr. Fox outlined the role of the epileptic in the state school, and Dr. McIntosh, in the colony. A large per cent of institutionalized epileptics are mentally deficient, and many others psychotic, and it was generally felt that there was no need for an epileptic colony as such. Several colonies had recently been converted into state schools or psychiatric institutions. Epileptics should be cared for in schools or hospitals, and such an arrangement might also increase the stimulus for further study of this condition.

The clergyman in the mental hospital is no longer a daring innovation, said Chaplain Donald C. Beatty of the Veterans Administration, who had previously asked for his topic to be expanded to include the entire religious program in the mental hospital. About one third of his group were clergymen, he said, one third administrators and one third ancillary workers.

Chaplain Beatty declared that it was important to realize that the goals and purposes of all interested disciplines, including the chaplaincy, were not in conflict, since they did overlap. He spoke of the socializing effect of singing familiar hymns, of standing and sitting at the same time and of the general feeling of unity which a religious program can give to mental patients.

Dr. Ralph M. Patterson of Ohio reported upon the session on the child patient in the mental hospital, which had been held under the chairmanship of Dr. Walter H. Baer of Illinois. Dr. Patterson said that the problem had been "thrust upon" most administrators, inasmuch as there were long lists of children in urgent need of care.

The location of an all-children's unit should be separate from but related to the state hospital, or alternatively, a teaching hospital. This would make it easier for the children to have the general medical and surgical facilities they might need. The size of units preferred varied from 25 to 150 children, but larger units have an advantage in that they can be located around a central facilities unit. In many cases patients had to be screened after admission since there were no facilities for screening except at the hospital. Screening before admission would be an advantage.

In the institution, five and ten year olds should be grouped together, boys and girls of pre-adolescent ages should form another group, having separate sleeping quarters but mingling during the day. For children twelve and over, separation from the younger groups was more satisfactory. Psychotic and non-psychotic children should be kept separate where possible.

The personnel needed would be more than for a similar sized adult group, and the child psychiatrist is essential, although they are difficult to get. The cost per patient for children's units would of course be higher than for adults. The group asked the American Psychiatric Association Committee on Child Psychiatry to take active and productive interest in the problem.

The therapeutic importance of clothing to the patient was emphasized by all the speakers in Dr. Ralph M. Chambers' panel on Clothing of the Mental Patient.

It was pointed out that allowing the patient to wear clothes brought from home was not merely a matter of economy but of raising the patient's own morale to an extraordinary extent. A hospital clothing program should be organized in a way which permits, as far as possible, the patient to be clothed according to standards which he himself has built up before he became a patient in a mental hospital. This may have much to do with the success or failure of the therapeutic program.

Miss Annie A. Hall of Virginia said that care of patients' clothing is of the greatest possible importance, since relatives and family resent requests for replacements when clothing already supplied has been neglected or badly treated.

Miss Dorothy E. Clark of California described the program set up by her Committee to establish a formula for calculating the clothing budget. Many of the recommendations of the committee have been adopted and with satisfactory results.

Despite the fact that several delegates seemed to think that the program was idealistic, it was plain that the general trend was to appreciate the therapeutic importance of patients' clothing, while being aware of the long task ahead in improving the general picture.

People & Places

Dr. Robert S. Garber, formerly assistant medical director of the New Jersey State Hospital at Trenton, replaces Dr. Diomede Guertin as medical director and superintendent of the N. J. State Village for Epileptics at Skillman. Dr. Guertin is now a staff consultant to the state's Department of Health. . . . Dr. Edmund W. Miller, Superintendent of Anoka (Minn.) State Hospital since 1943, passed away in July. . . . Dr. Harold A. Budd, former assistant director of Massillon State Hospital in Ohio, succeeds Dr. M. B. Gordon as Superintendent of Cleveland State Hospital. . . . Dr. Frank Adelman is the new superintendent of Western State Hospital, at Fort Supply, Okla.; previously he served as Clinical Director at Eastern State Hospital in Vinita. . . . Construction has begun on a million-dollar tuberculosis unit at Traverse City (Mich.) State Hospital. The 100-bed unit will also serve the Newberry State Hospital, 160 miles away. . . . Dr. George H. Preston has been appointed Clinical Administrator at Chestnut Lodge, Rockville, Md. . . . High Point Hospital in Port Chester, N. Y., announces the appointment of Mary Gangemi, R. N., as Director of Nursing. Miss Gangemi previously was Assistant Director of the Menninger Foundation School for Psychiatric Aides. . . . More New York State Hospital appointments: Dr. Nathan Beckenstein has been named director of Brooklyn State Hospital. He is succeeded as director of Syracuse Psychopathic Hospital by Dr. Richard F. Binzley, associate director of Pilgrim State Hospital. . . . The New York State Mental Hygiene Council has appointed Dr. Daniel Blain to serve as a consultant to its study of New York laws and procedures governing the release of mental patients. Dr. Blain has accepted the assignment as an individual, and not in his official capacity of Medical Director of A.P.A. and Director of Mental Hospital Service. . . . In Canada, Dr. R. D. Davison has been named Acting Director of Psychiatric Services in Saskatchewan during Dr. D. G. McKerracher's one-year leave. . . . M.H.S.'s Chief Consultant, Dr. Winfred Overholser, has been notified by the French government that they are awarding him their Medal of Liberation.

ALBERTA HEALTH SURVEY INCLUDES MENTAL HOSPITALS

A two-year study of public health needs recently completed in Alberta included several recommendations pertaining to the province's psychiatric installations. Suggestions were made for enlarging the mental hospitals and developing new mental health clinics in several areas. The survey report also recommends that a hostel be established to assist in the training and placement of patients discharged from the Red Deer Training School and that assistance under the Mothers' Allowance Act be made available to the wives and dependents of all patients admitted to mental institutions, if otherwise eligible. (15-2)

THE PATIENT DAY BY DAY

Recreation

GOLF COURSE PROVIDES VARYING ACTIVITIES

The nine-hole, professionally landscaped golf course at the Veterans Administration Hospital in Danville, Illinois, serves in several different ways in the resocialization of a large percentage of the hospital's psychotic patients.

Patients are encouraged to play in groups of three or four, although if one insists on going round alone, he is allowed to do so until he can be persuaded to join a group. Members of the country club, the municipal golf course and other agencies have formed a volunteer group to come out and play with the patients. And finally, the Manual Arts Therapy Section has developed a formal course in greens-keeping, in which nineteen patients at present take part, and are responsible for certain aspects of maintenance, such as cutting, manicuring, spiking and weeding the greens, maintaining the sand traps and the tees and carrying out structural alterations such as bridge building over water hazards.

During the season, the course is open to patients every weekday except from 4:30 to 6 p.m. when it is for the use of personnel. All day Saturday it is open to patients only, but Sunday morning play is not permitted so that golf will not conflict with religious services. Any patient on an open ward or a patient in a locked ward with ground privileges may play at any time when he is not occupied with prescribed treatment activities. In addition, certain patients play golf on a medical prescription.

Special Services provides trained sports technicians who give lessons, generally supervise and arrange tournaments. Occasionally one of the professionals from the country club comes out to give group instruction or to put on a demonstration game.

The medical staff of the hospital believes that activity on the golf course has contributed considerably to the improvement of patients who have been able to leave the hospital since.

The Chicago District Golf Association and other professional golfing associations supplied funds to buy athletic equipment and provide golfing facilities in a number of VA hospitals. (7-2)

Ancillary Services

PATIENT BRIEFS

During the week that movies could not be shown to patients because the projectionist was on vacation, the Jacksonville (Ill.) State Hospital was lent three large-screen television sets by a local dealer. . . . In order to encourage the occupational therapy work being done by family care patients from the Hudson River State Hospital at Poughkeepsie, a photographer was sent around to take pictures of the patients working on their OT projects. The completed articles are also put on display at the hospital. . . . The Milwaukee County (Wis.) Asylum has devised a plan for liquidating the spending-money of patients where the individual balance is too small to buy anything. Charge attendants have been instructed to total all such patients' accounts on their respective wards and to use the lump sum to buy goods which can be distributed equitably, such as candy, cookies, fruits, etc. among those patients. (23-3)

Nursing Service

NURSING EDUCATORS TOLD OF MENTAL HOSPITAL NEEDS

In order that all disciplines within the mental hospital may be made aware of the efforts of one of its member disciplines, the nursing profession, to provide more and better care for the mentally ill, MENTAL HOSPITALS presents the following abstract from the May 28 "League Letter" of the National League of Nursing Education:

"One of the largest groups of people requiring nursing service consists of patients in psychiatric hospitals . . . almost 700,000 patients. Psychiatric hospitals have 54 per cent of all hospitalized patients, 19 per cent of all hospital nursing personnel (professional and non-professional), 5 per cent of all the professional nurses who are in hospitals. There is one professional nurse for every 58 patients in psychiatric hospitals.

"In 1948 seven universities had a total of 9 programs in psychiatric and mental health nursing for graduate nurses. This spring, only four years later, there were 21 programs in 17 universities. This increase not only forecasts more nurses prepared as teachers of psychiatric nursing . . . (but) more administrators and supervisors for psychiatric nursing services . . . more psychiatric nurse specialists. It also promises a better understanding of the concepts and practices of psychiatric nursing on the part of all graduate nurses now studying in these 17 universities, regardless of the field in which they are receiving special preparation.

"In 1939 only half of the schools included psychiatric nursing experience in their basic programs. . . . In 1950 all but 10 per cent of the schools were offering clinical experience in this field.

"Our state leagues are active in keeping their members abreast of recent developments in psychiatric nursing, assisting them to learn more about the clinical facilities for their students' psychiatric nursing experience, aiding them in planning educational programs for all levels of psychiatric nursing personnel, serving as a channel through which they can work with other groups on the many problems that cannot be solved by nurses alone.

"The importance of . . . working with allied professional groups and especially with citizens groups should be heavily underscored. Public action for the improvement of psychiatric hospitals is a 'must' companion to any efforts by the nursing profession to improve nursing education and nursing care.

"Every League member should participate actively, to join hands with other groups working toward the same end—better care for the 700,000 patients in psychiatric hospitals." (16-2)

DISPOSABLE DRAW SHEET SAVES LAUNDRY ON INCONTINENT WARD

The V. A. Hospital at Coatesville, Pa., reports that as many as 128 sheets have been saved over a 24-hour period on its 50-bed ward for bedridden geriatric patients. This has been achieved by the use of a disposable pad used like a draw sheet. The pads are used under incontinent patients and as a sheet-protector when the urinal or bedpan is being used.

The pads consist of a 24x18 inch brown paper base with a one inch thickness of cellucotton filler, covered by a layer of guaze. These are made by volunteer workers from materials supplied by the hospital.

The soiled pads are destroyed immediately, and in addition to cutting down on the quantity of linens used, save the aides much time and effort.

Psychiatric Therapies

PREVENTIVE METHODS AGAINST DELAYED INSULIN REACTIONS

An item in a recent issue of the Veterans Administration Information Bulletin, Psychiatry and Neurology Division, deals with the problem of a secondary insulin reaction which may follow in the evening or later at night after a deep insulin coma treatment. One hospital dealt with it as follows:

"Recently we divided the patients who were subjects for delayed reactions into two groups. One group was given orange juice about 7 pm and again at 10:30 pm. The other group did not receive carbohydrates following their evening meal. After 3 weeks of the experiment it was noted that the group who had received the orange juice had no secondary reaction during the evening or later. Therefore, this plan was accepted as beneficial and all patients under deep insulin coma treatment are given orange juice as indicated above.

"At present we have only an occasional secondary reaction, possibly one a week. We have had no delayed reactions which have been considered emergent in nature. Since we have solved most of our secondary insulin reactions problems thus, we do not think it necessary to allow the nursing service to administer glucose for the occasional secondary reactions which are occurring at the present time." (18-3)

THERAPEUTIC SWIMMING POOL REPLACING HYDROTHERAPY

At the Veterans Administration Hospital at Bedford, Mass., the commonly used hydrotherapy methods of wet sheet packs and continuous tubs are gradually being replaced by a "therapeutic swimming pool." The Manager writes that this has contributed towards eliminating restraints and seclusion on acutely disturbed wards.

The swimming pool is 14 feet by 40, and the water is maintained at a temperature of 92 degrees Fahrenheit. This pool, which was formerly used as the recreation pool, can accommodate from 12 to 14 patients comfortably. The treatment period is one hour for each group and five groups are treated daily.

The patients are encouraged to swim and to take part in water sports such as water polo, basketball shooting and racing. Specially trained personnel, who take part and encourage the patients, also enforce safety factors and furnish the necessary supervision.

Using the pool instead of the more conventional methods, the hospital treats four times as many patients with the same number of staff members, and has been able to eliminate the 24 hour hydrotherapy service which was necessary previously.

The pool has been in use for two years, and as well as the elimination of mechanical restraints and the near abolishment of wet sheet packs and continuous tubs, has resulted in the abolishment of observation dormitories and the almost complete elimination of seclusion rooms, a generally quieter ward atmosphere and a saving in personnel. Moreover, it is plainly a more pleasant and agreeable form of hydrotherapy for neuropsychiatric patients. (18-2)

Public Relations

MENTAL HEALTH COUNCIL FORMED IN OHIO

A Mental Health Council for the Dayton (Ohio) State Hospital district, believed to be the first such organization of its type in the state, was formed recently with the principal of a local high school as President.

The objectives of the Council are:

1) To take necessary steps to conserve, protect and improve the mental and emotional health of the people of the Dayton State Hospital district.

2) To promote administrative and legislative action to establish modern programs in the district for the promotion of mental health and the prevention of mental illness.

3) To take necessary steps to insure adequate housing for personnel and patients of the state hospital.

4) To obtain adequate and proper care for the mentally ill, mentally deficient, epileptic, alcoholic and all persons suffering from personality disorders.

5) To promote the estabishment of clinics and other facilities throughout the district for out-patient treatment.

Judge Rodney Love of Montgomery County acted as temporary chairman, prior to the election of officers. He said the organization was being formed, not as a "lobby" but as a group to look into the needs of the Dayton State Hospital. (2-2)

BEERS' BOOK AGAIN HELPS MENTAL HEALTH REFORM

The story of Clifford W. Beers' famous book, "The Mind That Found Itself," has been presented in dramatic form under the title "My Name Is Legion." The play started on a seven week tour of 15 states late in September.

The play's production is a joint enterprise of the American Theatre Wing and the National Association for Mental Health, and will serve as a preview of the N.A.M.H. 1953 campaign which will be, says the Association's executive director, a "down-to-earth action crusade to provide the mentally ill with the same caliber of care and medical treatment which is given to the physically ill."

The play, which had its first performance in the spring with an all-Broadway cast, will be sponsored in 38 cities by community mental health associations.

Psychiatrists and theatrical people have declared that the play is both good theatre and good mental health education. (2-3)

Legislation

MISSISSIPPI REPORTS ON BUDGET SUCCESSES

Dr. W. L. Jaquith, superintendent of the Mississippi State Hospital at Whitfield, has sent us details of the appropriations granted to the three state institutions for the current biennium, 1952-54.

The sum granted represented a 23% increase over the 1950-52 sum, which itself had been 53% above the previous amount granted.

Dr. Jaquith believes it is because he made a direct appeal through local newspapers to the people of the state, as well as to the legislators. He pointed out that the budgets were totally inadequate for the care of Mississippi's mentally ill. There was a flood of editorial comment in state newspapers about this action, and a public demand was made to the Legislature to provide adequate funds for the care of psychiatric patients.

During the last session of the Legislature, the institutions had very little difficulty and were asked to name their own figures relative to institutional needs.

The three mental hospitals are administered by a non-political board of outstanding citizens. Each institution works up its own budget and submits it to the State Budget Commission, which recommends to the Legislature the amount of money to be allocated to each division of State government. The hospitals' Board of Trustees is given a hearing in the House and Senate Chambers of the State Legislature and the budgets are discussed. If the Legislature feels that the hospitals need more than the amount allocated by the Budget Commission, it has the authority to give the necessary funds.

Since money has been received in adequate amounts, the overall patient care has been markedly improved. Dr. Jaquith states that the hospitals are now functioning as they should have functioned these many years. (15-3)

ADMINISTRATIVE INNOVATIONS

(Continued from page 4)

reputation was employed to make a survey of our housekeeping department. Her report contained many constructive suggestions. Among other improvements resulting, a greater specialization of duties was effected, such as assignment of porters to specific duties throughout the hospital, rather than having one porter do all types of work. For example, maintenance of all floors was assigned to personnel trained for that work, as was window washing, and similar housekeeping duties.

"Traditionally, as in all hospitals, we received many complaints about our coffee. After a trial on one nursing unit, serving pantries were equipped with vacuum coffee makers and furnished with individual containers holding the right amount of coffee for each. Now we rarely have a complaint regarding our coffee, and in addition save several hundred dollars a year by eliminating waste.

"Another innovation in the dietary department was the inauguration of a snack service for patients. This is available from 9:00 a.m. to 9:00 p.m., and consists of such items as juices, beverages, soups, sandwiches, fruit and ice cream. A patient may order and have charged to his account any items on the snack service menu for himself and visitors.

"A weekly menu conference was organized. This is regularly attended by the assistant administrator, the chief dietitian, her first assistant, and the purchasing agent; the administrator attending occasionally. In this way the purchasing agent can keep the dietitians informed regarding market conditions and about food products on hand in the store room.

"At the suggestion of one of our Trustees, an arrangement was made with one of the prominent banks of the city whereby patients can finance their hospital accounts over a period of months at a moderate fee. This makes the amount due the hospital immediately available and improves collections. The patients have welcomed this opportunity of making monthly payments and in most instances were much relieved of financial worry when told the plan was available.

The Report was made by Robert P. Bonnie, President of the Board of Trustees. Mr. Bonnie ends his message, "In conclusion, I would like to impress upon all connected with the Infirmary that our primary purpose is to give efficient, economical and sympathetic care to our sick. This we cannot do unless our plant is kept up to the minute; unless it is made a pleasant place for both patients and workers; and accompanied by cheerful, courteous service from loyal personnel. Let us keep ever in mind our goal of 'the best, if not the biggest hospital in Louisville'."